Adopted	Rejected

COMMITTEE REPORT

YES:	10
NO:	0

MR. SPEAKER:

Your Committee on **Financial Institutions**, to which was referred Senate Bill 171, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill **be amended** as follows:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning insurance and to make an appropriation.

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 16-39-9-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. A provider may not charge a person for making and providing copies of medical records an amount greater than ~~provided in this chapter~~. **the amount set in rules adopted by the department of insurance under section 4 of this chapter.**

SECTION 2. IC 16-39-9-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4. (a) As used in this section, "department" refers to the department of insurance created by IC 27-1-1-1.

(b) ~~Notwithstanding sections 1 and 2 of this chapter,~~ The

department may adopt rules under IC 4-22-2 to ~~adjust~~ **set** the amounts that may be charged for copying records under this chapter. In adopting rules under this section, the department shall consider the following factors relating to the costs of copying medical records:

(1) The following labor costs:

(A) Verification of requests.

(B) Logging requests.

(C) Retrieval.

(D) Copying.

(E) Refiling.

(2) Software costs for logging requests.

(3) Expense costs for copying.

(4) Capital costs for copying.

(5) Billing and bad debt expenses.

(6) Space costs.

SECTION 3. IC 20-12-22.3 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 22.3. Insurance Education Scholarship Fund

Sec. 1. As used in this chapter, "commission" refers to the state student assistance commission established by IC 20-12-21-4.

Sec. 2. As used in this chapter, "fund" refers to the insurance education scholarship fund established by section 5 of this chapter.

Sec. 3. As used in this chapter, "insurance student" means a student who studies or intends to study:

(1) insurance; or

(2) business with an emphasis on insurance.

Sec. 4. As used in this chapter,"state educational institution" has the meaning set forth in IC 20-12-0.5-1.

Sec. 5. (a) The insurance education scholarship fund is established to encourage and promote qualified individuals to pursue a career in insurance in Indiana.

(b) The fund consists of amounts deposited under IC 27-1-15.6-7.3.

Sec. 6. (a) The commission shall administer the fund.

(b) The expenses of administering the fund shall be paid from money in the fund.

(c) The treasurer of state shall invest the money in the fund not

currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from the investments shall be deposited in the fund.

(d) Money in the fund at the end of a state fiscal year does not revert to the state general fund.

(e) There is annually appropriated to the commission all money in the fund to carry out the purposes of this chapter.

Sec. 7. (a) The money in the fund shall be used to provide annual scholarships to insurance students who qualify under section 9 of this chapter. The commission shall determine the amount of money to be allocated from the fund for scholarships under this chapter.

(b) A scholarship awarded under this chapter may be used only for the payment of tuition or fees that are:

(1) approved by the state educational institution that awards the scholarship; and

(2) not otherwise payable under any other scholarship or form of financial assistance specifically designated for tuition or fees.

(c) Subject to section 8(c) of this chapter, each scholarship awarded under this chapter is renewable under section 9 of this chapter for a total number of terms that does not exceed eight (8) full-time semesters (or the equivalent) or twelve (12) full-time quarters (or the equivalent).

Sec. 8. (a) The commission for higher education shall provide the commission with the most recent information concerning the number of insurance students at each state educational institution.

(b) The commission shall allocate the available money from the fund to each state educational institution that has:

(1) an insurance program; or

(2) a business program with an emphasis on insurance;

in proportion to the number of insurance students enrolled at each state educational institution based upon the information received by the commission under subsection (a).

(c) Each state educational institution shall determine which of the state educational institution's insurance students who apply qualify under section 9 of this chapter. In addition, the state educational institution shall consider the need of the applicant when awarding scholarships under this chapter.

(d) The state educational institution may not grant a scholarship renewal to an insurance student for an academic year that ends later than six (6) years after the date on which the insurance student received the insurance student's initial scholarship under this chapter.

(e) Any funds that:

(1) are allocated to a state educational institution under section 8(b) of this chapter; and

(2) are not used for scholarships under this chapter;

shall be returned to the commission for reallocation by the commission to any other eligible state educational institution in need of additional funds.

Sec. 9. To qualify for a scholarship or a scholarship renewal from the fund, an insurance student must:

(1) be admitted to an approved state educational institution as a full-time or part-time insurance student; and

(2) meet the qualifications established by the commission under section 11 of this chapter.

Sec. 10. (a) The commission shall maintain complete and accurate records in administering the fund, including records concerning the scholarships awarded under this chapter.

(b) Each state educational institution shall provide the commission with information concerning the following:

(1) The awarding of scholarships under this chapter.

(2) The academic progress made by each recipient of a scholarship under this chapter.

(3) Other pertinent information requested by the commission.

Sec. 11. The commission shall adopt rules under IC 4-22-2 necessary to carry out this chapter, including rules establishing qualifications for recipients of scholarships and scholarship renewals under this chapter.

SECTION 4. IC 27-1-3-15 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 15. (a) Except as provided in subsection ~~(g),~~ **(h),** the commissioner shall collect the following filing fees:

Document	Fee
Articles of incorporation	$ 350
Amendment of articles of	

incorporation	$ 10
Filing of annual statement and consolidated statement	$ 100
Annual renewal of company license fee	$ 50
Withdrawal of certificate of authority	$ 25
Certified statement of condition	$ 5
Any other document required to be filed by this article	$ 25

The commissioner shall deposit fees collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(b) The commissioner shall collect a fee of ten dollars ($10) each time process is served on the commissioner under this title.

(c) The commissioner shall collect the following fees for copying and certifying the copy of any filed document relating to a domestic or foreign corporation:

Per page for copying	As determined by the commissioner but not to exceed actual cost
For the certificate	$10

(d) Each domestic and foreign insurer **and each health maintenance organization** shall remit annually to the commissioner for deposit into the department of insurance fund established by ~~IC 27-1-3-28~~ ~~three hundred fifty~~ **section 28 of this chapter one thousand** dollars ~~($350)~~ **($1,000)** as an internal audit fee. All assessment insurers, farm mutuals, **and** fraternal benefit societies ~~and health maintenance organizations~~ shall remit to the commissioner for deposit into the department of insurance fund ~~one~~ **two** hundred **fifty** dollars ~~($100)~~ **($250)** annually as an internal audit fee.

(e) Beginning July 1, 1994, each insurer shall remit to the commissioner for deposit into the department of insurance fund established by ~~IC 27-1-3-28~~ **section 28 of this chapter** a fee of thirty-five dollars ($35) for each policy, rider, ~~and~~ **rule, rate, or** endorsement filed with the state, **including subsequent filings. Except as provided in subsection (f), each policy, rider, rule, rate, or endorsement that is filed as part of a particular product filing or**

in association with a particular product filing is an individual filing subject to the fee under this subsection. However, ~~each policy, rider, and endorsement filed as part of a particular product filing and associated with that product filing shall be considered to be a single filing and subject only to one (1) thirty-five dollar ($35) fee.~~ **the total amount of fees paid under this subsection by each insurer for a particular product filing may not exceed one thousand dollars ($1,000).**

(f) Beginning July 1, 2009, a policy, rider, rule, rate, or endorsement that is filed as part of a particular product filing or in association with a particular product filing for a commercial product described in:

(1) Class 2(b), Class 2(c), Class 2(d), Class 2(e), Class 2(f), Class 2(g), Class 2(h), Class 2(i), Class 2(j), Class 2(k), Class 2(l), or Class 2(m) of IC 27-1-5-1; or

(2) Class 3 of IC 27-1-5-1;

is considered to be part of a single filing for which the insurer is subject only to one (1) thirty-five dollar ($35) fee under subsection (e).

~~(f)~~ **(g)** The commissioner shall pay into the state general fund by the end of each calendar month the amounts collected during that month under subsections ~~(a),~~ (b) and (c).

~~(g)~~ **(h)** The commissioner may not collect fees for quarterly statements filed under IC 27-1-20-33.

~~(h)~~ **(i)** The commissioner may adopt rules under IC 4-22-2 to provide for the accrual and quarterly billing of fees under this section.

SECTION 5. IC 27-1-3-28 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 28. (a) The department of insurance fund is established for the following purposes:

(1) To provide supplemental funding for the operations of the department of insurance.

(2) To pay the costs of hiring and employing staff.

(3) To provide staff salary differentials as necessary to equalize the average salaries and staffing levels of the department of insurance with the average salaries and staffing levels reported in the most recent Insurance Department Resources Report published by the National Association of Insurance Commissioners.

(4) To enable the department of insurance to maintain accreditation by the National Association of Insurance Commissioners.

(5) To carry out any other purpose determined necessary by the department of insurance to carry out the department's duties under this title.

(b) The fund shall be administered by the commissioner. The following shall be deposited in the department of insurance fund:

(1) Audit fees remitted by insurers to the commissioner under ~~IC 27-1-3-15(d).~~ **section 15(d) of this chapter.**

(2) Filing fees remitted by insurers to the commissioner under ~~IC 27-1-3-15(e).~~ **section 15(a) or 15(e) of this chapter.**

(3) Any other amounts remitted to the commissioner or the department that are required by rule or statute to be deposited into the department of insurance fund.

(c) The expenses of administering the fund shall be paid from money in the fund.

(d) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from these investments shall be deposited in the fund.

(e) Money in the fund at the end of a particular fiscal year does not revert to the state general fund.

(f) There is annually appropriated to the department of insurance, for the purposes set forth in subsection (a), the entire amount of money deposited in the fund in each year.

SECTION 6. IC 27-1-12.7-10, AS AMENDED BY P.L.193-2006, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. Notwithstanding any other provision of law:

(1) the commissioner has the sole authority to regulate the issuance and sale of funding agreements;

(2) a funding agreement is not considered a covered policy under IC 27-8-8-1(a) or IC 27-8-8-2.3(d); ~~and~~

(3) a claim for payments under a funding agreement must be treated as a loss claim described in Class 2 of IC 27-9-3-40; **and**

(4) assets supporting a funding agreement in a segregated asset account under section 8 of this chapter are subject to IC 27-9-3-40.5 and Class 1(c) of IC 27-1-5-1.

SECTION 7. IC 27-1-13-16 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 16. (a) This section applies to a policy of insurance that:**

(1) covers first party loss to property located in Indiana; and

(2) insures against loss or damage to:

(A) real property consisting of not more than four (4) residential units, one (1) of which is the principal place of residence of the named insured; or

(B) personal property in which the named insured has an insurable interest and that is used within a residential dwelling for personal, family, or household purposes.

(b) An insurer that reduces, restricts, or removes, through a rider or an endorsement, coverage provided by a policy of insurance must provide, by United States mail, written notice to the policyholder of the changes to the policy. The written notice required by this subdivision must:

(A) be part of a document that is:

(i) separate from the endorsement or rider; and

(ii) at least eight and one half (8 1/2) by eleven (11) inches in size;

(B) be printed in at least 12 point type, 1 point leaded;

(C) consist of text that achieves a minimum score of forty (40) on the Flesch reading ease test or an equivalent score on a comparable test approved by the commissioner as provided by IC 27-1-26-6;

(D) identify the forms, provisions, or endorsements that are changed;

(E) indicate the name and contact information of:

(i) the servicing agent for the policy, if any; and

(ii) the insurer;

whom the policyholder may contact for assistance with any questions concerning the proposed policy changes; and

(F) indicate any premium adjustment caused by the reported changes and set forth any options available to the policyholder to repurchase the coverage that will be removed, restricted, or reduced.

(c) The outside of the envelope used to mail the notice required

under subsection (b) must contain the following statement in at least 14 point type: "Coverage has been reduced, restricted, or removed from your policy.".

(d) The insurer bears the burden to prove that the policyholder was notified in accordance with this section.

(e) The commissioner may adopt rules under IC 4-22-2 to implement this section.

SECTION 8. IC 27-1-13-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 17. (a) This section applies to a policy of insurance that:**

(1) covers first party loss to property located in Indiana; and

(2) insures against loss or damage to:

(A) real property consisting of not more than four (4) residential units, one (1) of which is the principal place of residence of the named insured; or

(B) personal property in which the named insured has an insurable interest and that is used within a residential dwelling for personal, family, or household purposes.

(b) A policy of insurance described in subsection (a) may not be issued, renewed, or delivered to any person in Indiana if the policy limits a policyholder's right to bring an action against an insurer to a period of less than two (2) years from the date of loss.

SECTION 9. IC 27-1-15.6-7.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 7.3. (a) The commissioner may design or have designed an insurance producer certificate suitable for framing and display.**

(b) Upon request of an insurance producer, the commissioner may issue a certificate described in subsection (a).

(c) The commissioner may impose and collect a reasonable fee for a certificate issued under subsection (b). The commissioner shall deposit fees collected under this subsection into the insurance education scholarship fund established by IC 20-12-22.3.

(d) The commissioner shall establish guidelines to implement this section.

SECTION 10. IC 27-1-15.6-24.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2007]: **Sec. 24.1. A licensed insurance producer may charge a reasonable fee for personal lines property and casualty insurance or services related to personal lines property and casualty insurance subject to the following requirements:**

(1) The amount of a fee and the basis for calculating a fee may not vary among personal lines insureds.

(2) The amount of a fee is subject to the approval of the commissioner.

SECTION 11. IC 27-1-15.6-32 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 32. (a) The department shall adopt rules under IC 4-22-2 to set fees for licensure under this chapter, IC 27-1-15.7, and IC 27-1-15.8.

(b) Insurance producer and limited lines producer license renewal fees are due every ~~four (4)~~ **two (2)** years. The fee charged by the department every ~~four (4)~~ **two (2)** years for a:

(1) resident license is forty dollars ($40); and

(2) nonresident license is ninety dollars ($90).

(c) Consultant renewal fees are due every twenty-four (24) months.

(d) Surplus lines producer renewal fees are due ~~annually.~~ **every two (2) years. The fee charged by the department every two (2) years for a:**

(1) resident license is eighty dollars ($80); and

(2) nonresident license is one hundred twenty dollars ($120).

(e) The commissioner may issue a duplicate license for any license issued under this chapter. The fee charged by the commissioner for the issuance of a duplicate:

(1) insurance producer license;

(2) surplus lines producer license;

(3) limited lines producer license; or

(4) consultant license;

may not exceed ten dollars ($10).

(f) A fee charged and collected under this section shall be deposited into the department of insurance fund established by IC 27-1-3-28.

SECTION 12. IC 27-1-15.7-2, AS AMENDED BY P.L.73-2006, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. (a) Except as provided in subsection (b), to

renew a license issued under IC 27-1-15.6:

(1) a resident insurance producer must complete at least ~~forty (40)~~ **twenty (20)** hours of credit in continuing education courses; and

(2) a resident limited lines producer must complete at least ~~ten (10)~~ **five (5)** hours of credit in continuing education courses.

An attorney in good standing who is admitted to the practice of law in Indiana and holds a license issued under IC 27-1-15.6 may complete all or any number of hours of continuing education required by this subsection by completing an equivalent number of hours in continuing legal education courses that are related to the business of insurance.

(b) To renew a license issued under IC 27-1-15.6, a limited lines producer with a title qualification under IC 27-1-15.6-7(a)(8) must complete at least ~~fourteen (14)~~ **seven (7)** hours of credit in continuing education courses related to the business of title insurance with at least one (1) hour of instruction in a structured setting or comparable self-study in each of the following:

(1) Ethical practices in the marketing and selling of title insurance.

(2) Title insurance underwriting.

(3) Escrow issues.

(4) Principles of the federal Real Estate Settlement Procedures Act (12 U.S.C. 2608).

An attorney in good standing who is admitted to the practice of law in Indiana and holds a license issued under IC 27-1-15.6 with a title qualification under IC 27-1-15.6-7(a)(8) may complete all or any number of hours of continuing education required by this subsection by completing an equivalent number of hours in continuing legal education courses related to the business of title insurance or any aspect of real property law.

(c) The following insurance producers are not required to complete continuing education courses to renew a license under this chapter:

(1) A limited lines producer who is licensed without examination under IC 27-1-15.6-18(1) or IC 27-1-15.6-18(2).

(2) A limited line credit insurance producer.

(3) An insurance producer who is at least seventy (70) years of age and has been a licensed insurance producer continuously for at least twenty (20) years immediately preceding the license renewal date.

(d) To satisfy the requirements of subsection (a) or (b), a licensee may use only those credit hours earned in continuing education courses completed by the licensee:

(1) after the effective date of the licensee's last renewal of a license under this chapter; or

(2) if the licensee is renewing a license for the first time, after the date on which the licensee was issued the license under this chapter.

(e) If an insurance producer receives qualification for a license in more than one (1) line of authority under IC 27-1-15.6, the insurance producer may not be required to complete a total of more than ~~forty (40)~~ **twenty (20)** hours of credit in continuing education courses to renew the license.

(f) Except as provided in subsection (g), a licensee may receive credit only for completing continuing education courses that have been approved by the commissioner under section 4 of this chapter.

(g) A licensee who teaches a course approved by the commissioner under section 4 of this chapter shall receive continuing education credit for teaching the course.

(h) When a licensee renews a license issued under this chapter, the licensee must submit:

(1) a continuing education statement that:

(A) is in a format authorized by the commissioner;

(B) is signed by the licensee under oath; and

(C) lists the continuing education courses completed by the licensee to satisfy the continuing education requirements of this section; and

(2) any other information required by the commissioner.

(i) A continuing education statement submitted under subsection (h) may be reviewed and audited by the department.

(j) A licensee shall retain a copy of the original certificate of completion received by the licensee for completion of a continuing education course.

(k) A licensee who completes a continuing education course that:

(1) is approved by the commissioner under section 4 of this chapter;

(2) is held in a classroom setting; and

(3) concerns ethics;

shall receive continuing education credit for the number of hours for which the course is approved plus additional hours, not to exceed two (2) hours in a renewal period, equal to the number of hours for which the course is approved.

SECTION 13. IC 27-1-15.8-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4. ~~(a) During the period that a resident surplus lines producer's license is in effect, the licensee shall keep in force a bond in the penal sum of not less than twenty thousand dollars ($20,000) with an authorized corporate surety approved by the commissioner. The aggregate liability of the surety for any and all claims on a bond does not exceed the penal sum of the bond. A bond may not be terminated unless written notice of termination is provided by the surety to the licensee and the commissioner not less than thirty (30) days before termination. Upon termination of a resident license for which a bond was in effect, the commissioner shall notify the surety of the termination within ten (10) business days. All surety protection under this section inures to the benefit of the state of Indiana to assure the payment of all premium taxes.~~

~~(b) A resident surplus lines producer shall, at the time of an initial filing under subsection (c), file with the commissioner proof of the bond in the amount required under subsection (a). In each subsequent calendar year, the resident surplus lines producer shall file proof that the bond remains in effect. A subsequent filing under this subsection shall be made in conjunction with the annual filing required under subsection (c).~~

~~(c)~~ **(a)** In addition to all other charges, fees, and taxes that may be imposed by law, a surplus lines producer licensed under this chapter shall, on or before February 1 and August 1 of each year, collect from the insured and remit to the department for the use and benefit of the state of Indiana an amount equal to two and one-half percent (2 1/2%) of all gross premiums upon all policies and contracts procured by the surplus lines producer under the provisions of this section during the preceding six (6) month period ending December 31 and June 30, respectively. The declarations page of a policy referred to in this subsection must itemize the amounts of all charges for taxes, fees, and premiums.

~~(d)~~ **(b)** A licensed surplus lines producer shall execute and file with

the department of insurance on or before the twentieth day of each month an affidavit that specifies all transactions, policies, and contracts procured during the preceding calendar month, including:

(1) the description and location of the insured property or risk and the name of the insured;

(2) the gross premiums charged in the policy or contract;

(3) the name and home office address of the insurer whose policy or contract is issued, and the kind of insurance effected; and

(4) a statement that:

(A) the licensee, after diligent effort, was unable to procure from any insurer authorized to transact the particular class of insurance business in Indiana the full amount of insurance required to protect the insured; and

(B) the insurance placed under this chapter is not placed for the purpose of procuring it at a premium rate lower than would be accepted by an insurer authorized and licensed to transact insurance business in Indiana.

~~(e)~~ **(c)** A licensed surplus lines producer shall file with the department, not later than March 31 of each year, the financial statement, dated as of December 31 of the preceding year, of each unauthorized insurer from whom the surplus lines producer has procured a policy or contract. The insurance commissioner may, in the commissioner's discretion, after reviewing the financial statement of the unauthorized insurer, order the surplus lines producer to cancel an unauthorized insurer's policies and contracts if the commissioner is of the opinion that the financial statement or condition of the unauthorized insurer does not warrant continuance of the risk.

~~(f)~~ **(d)** A licensed surplus lines producer shall keep a separate account of all business transacted under this section. The account may be inspected at any time by the commissioner or the commissioner's deputy or examiner.

~~(g)~~ **(e)** An insurer that issues a policy or contract to insure a risk under this section is considered to have appointed the commissioner as the insurer's attorney upon whom process may be served in Indiana in any suit, action, or proceeding based upon or arising out of the policy or contract.

~~(h)~~ **(f)** The commissioner may revoke or refuse to renew a surplus lines producer's license for failure to comply with this section.

~~(i)~~ **(g)** A surplus lines producer licensed under this chapter may accept and place policies or contracts authorized under this section for an insurance producer duly licensed in Indiana, and may compensate the insurance producer even though the insurance producer is not licensed under this chapter.

~~(j)~~ **(h)** If a surplus lines producer does not remit an amount due to the department within the time prescribed in subsection ~~(c),~~ **(a),** the commissioner shall assess the surplus lines producer a penalty of ten percent (10%) of the amount due. The commissioner shall assess a further penalty of an additional one percent (1%) of the amount due for each month or portion of a month that any amount due remains unpaid after the first month. Penalties assessed under this subsection are payable by the surplus lines producer and are not collectible from an insured.

SECTION 14. IC 27-1-22-4, AS AMENDED BY P.L.193-2006, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4. (a) Every insurer shall file with the commissioner every manual of classifications, rules, and rates, every rating schedule, every rating plan, and every modification of any of the foregoing which it proposes to use.

(b) The following types of insurance are exempt from the requirements of subsections (a) and (j):

(1) Inland marine risks, which by general custom of the business are not written according to manual rates or rating plans.

(2) Insurance ~~other than workers compensation insurance,~~ that is:

(A) written by an insurer that:

(i) complies with subsection (m) and

~~(ii)~~ maintains at least a B rating by A.M. Best or an equivalent rating by another independent insurance rating organization; **or**

(ii) is approved for an exemption by the commissioner; and

(B) issued to commercial policyholders.

(c) Every such filing shall indicate the character and extent of the coverage contemplated and shall be accompanied by the information upon which the filer supports such filing.

(d) The information furnished in support of a filing may include:

(1) the experience and judgment of the insurer or rating

organization making the filing;

(2) its interpretation of any statistical data it relies upon;

(3) the experience of other insurers or rating organizations; or

(4) any other relevant factors.

The commissioner shall have the right to request any additional relevant information. A filing and any supporting information shall be open to public inspection as soon as stamped "filed" within a reasonable time after receipt by the commissioner, and copies may be obtained by any person on request and upon payment of a reasonable charge therefor.

(e) Filings shall become effective upon the date of filing by delivery or upon date of mailing by registered mail to the commissioner, or on a later date specified in the filing.

(f) Specific inland marine rates on risks specially rated, made by a rating organization, shall be filed with the commissioner.

(g) Any insurer may satisfy its obligation to make any such filings by becoming a member of, or a subscriber to, a licensed rating organization which makes such filings and by authorizing the commissioner to accept such filings on its behalf, provided that nothing contained in this chapter shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization or as requiring any member or subscriber to authorize the commissioner to accept such filings on its behalf.

(h) Every insurer which is a member of or a subscriber to a rating organization shall be deemed to have authorized the commissioner to accept on its behalf all filings made by the rating organization which are within the scope of its membership or subscribership, provided:

(1) that any subscriber may withdraw or terminate such authorization, either generally or for individual filings, by written notice to the commissioner and to the rating organization and may then make its own independent filings for any kinds of insurance, or subdivisions, or classes of risks, or parts or combinations of any of the foregoing, with respect to which it has withdrawn or terminated such authorization, or may request the rating organization, within its discretion, to make any such filing on an agency basis solely on behalf of the requesting subscriber; and

(2) that any member may proceed in the same manner as a subscriber unless the rating organization shall have adopted a

rule, with the approval of the commissioner:

(A) requiring a member, before making an independent filing, first to request the rating organization to make such filing on its behalf and requiring the rating organization, within thirty (30) days after receipt of such request, either:

(i) to make such filing as a rating organization filing;

(ii) to make such filing on an agency basis solely on behalf of the requesting member; or

(iii) to decline the request of such member; and

(B) excluding from membership any insurer which elects to make any filing wholly independently of the rating organization.

(i) Under such rules as the commissioner shall adopt, the commissioner may, by written order, suspend or modify the requirement of filing as to any kinds of insurance, or subdivision, or classes of risk, or parts or combinations of any of the foregoing, the rates for which cannot practicably be filed before they are used. Such orders and rules shall be made known to insurers and rating organizations affected thereby. The commissioner may make such examination as the commissioner may deem advisable to ascertain whether any rates affected by such order are excessive, inadequate, or unfairly discriminatory.

(j) Upon the written application of the insured, stating the insured's reasons therefor, filed with the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

(k) An insurer shall not make or issue a policy or contract except in accordance with filings which are in effect for that insurer or in accordance with the provisions of this chapter. Subject to the provisions of section 6 of this chapter, any rates, rating plans, rules, classifications, or systems in effect on May 31, 1967, shall be continued in effect until withdrawn by the insurer or rating organization which filed them.

(l) The commissioner shall have the right to make an investigation and to examine the pertinent files and records of any insurer, insurance producer, or insured in order to ascertain compliance with any filing for rate or coverage which is in effect. The commissioner shall have the right to set up procedures necessary to eliminate noncompliance,

whether on an individual policy, or because of a system of applying charges or discounts which results in failure to comply with such filing.

(m) This subsection applies to an insurer that issues a commercial property or commercial casualty insurance policy to a commercial policyholder. Not more than thirty (30) days after the insurer begins using a commercial property or commercial casualty insurance:

(1) rate;

(2) rating plan;

(3) manual of classifications; ~~or~~

(4) form; or

~~(4)~~ **(5)** modification of an item specified in subdivision (1), (2), ~~or~~ (3), **or (4);**

the insurer shall file with the department, for informational purposes only, the item specified in subdivision (1), (2), (3), ~~or~~ (4), **or (5).** Use of an item specified in subdivision (1), (2), (3), ~~or~~ (4), **or (5)** is not conditioned on review or approval by the department. This subsection does not require filing of an individual policy rate if the original manuals, rates, and rules for the insurance plan or program to which the individual policy conforms has been filed with the department.

(n) ~~Subsection (m) does not apply to~~ **An insurer that issues a commercial property or commercial casualty insurance** policy ~~forms.~~ **form, endorsement, or rider that is prepared to provide or exclude coverage for an unusual or extraordinary risk of a particular commercial policyholder must maintain the policy form, endorsement, or rider in the insurer's Indiana office and provide the policy form, endorsement, or rider to the commissioner at the commissioner's request.**

(o) If coverage under a commercial property or commercial casualty insurance policy is changed upon renewal of the policy, the insurer shall provide written notice to the:

(1) policyholder; and

(2) insurance producer through which the policyholder obtained the coverage;

that coverage under the policy has changed.

SECTION 15. IC 27-1-25-12.2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 12.2. (a) An administrator that:

(1) performs the duties of an administrator in Indiana; and

(2) does not hold a license issued under section 11.1 of this chapter;

shall obtain a nonresident administrator license under this section by filing a uniform application with the commissioner.

(b) Unless the commissioner verifies the nonresident administrator's home state license status through an electronic data base maintained by the NAIC or by an affiliate or a subsidiary of the NAIC, a uniform application filed under subsection (a) must be accompanied by a letter of certification from the nonresident administrator's home state, verifying that the nonresident administrator holds a resident administrator license in the home state.

(c) A nonresident administrator is not eligible for a nonresident administrator license under this section unless the nonresident administrator is licensed as a resident administrator in a home state that has a law or regulation that is substantially similar to this chapter.

(d) Except as provided in subsections (b) and (h), the commissioner shall issue a nonresident administrator license to a nonresident administrator that makes a filing under subsections (a) and (b) upon receipt of the filing.

(e) Unless a nonresident administrator is notified by the commissioner that the commissioner is able to verify the nonresident administrator's home state licensure through an electronic data base described in subsection (b), the nonresident administrator shall:

(1) on September 15 of each year, file a statement with the commissioner affirming that the nonresident administrator maintains a current license in the nonresident administrator's home state; and

(2) pay a filing fee as required by the commissioner.

The commissioner shall collect a filing fee required under subdivision (2) and deposit the fee into the department of insurance fund established by IC 27-1-3-28.

(f) A nonresident administrator that applies for licensure under this section shall:

(1) produce the accounts of the nonresident administrator;

(2) produce the records and files of the nonresident administrator for examination; and

(3) make the officers of the nonresident administrator available to provide information with respect to the affairs of the nonresident

administrator;

when reasonably required by the commissioner.

(g) A nonresident administrator is not required to hold a nonresident administrator license in Indiana if the nonresident administrator's function in Indiana is limited to the administration of life, health, or annuity coverage for a total of not more than one hundred (100) Indiana residents.

(h) The commissioner may refuse to issue or may delay the issuance of a nonresident administrator license if the commissioner determines that:

(1) due to events occurring; or

(2) based on information obtained;

after the nonresident administrator's home state's licensure of the nonresident administrator, the nonresident administrator is unable to comply with this chapter or grounds exist for the home state's revocation or suspension of the nonresident administrator's home state license.

(i) If the commissioner makes a determination described in subsection (h), the commissioner:

(1) shall provide written notice of the determination to the insurance regulator of the nonresident administrator's home state; and

(2) may delay the issuance of a nonresident administrator license to the nonresident administrator until the commissioner determines that the nonresident administrator is able to comply with this chapter and that grounds do not exist for the home state's revocation or suspension of the nonresident administrator's home state license.

SECTION 16. IC 27-1-25-12.3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 12.3. (a) An administrator that is licensed under section 11.1 of this chapter shall, not later than July 1 of each year unless the commissioner grants an extension of time for good cause, file a report for the previous calendar year that complies with the following:

(1) The report must contain financial information reflecting a positive net worth prepared in accordance with section 11.1(b)(4) of this chapter.

(2) The report must be in the form and contain matters prescribed

by the commissioner.

(3) The report must be verified by at least two (2) officers of the administrator.

(4) The report must include the complete names and addresses of insurers with which the administrator had a written agreement during the preceding fiscal year.

(5) The report must be accompanied by a filing fee determined by the commissioner.

The commissioner shall collect a filing fee paid under subdivision (5) and deposit the fee into the department of insurance fund established by IC 27-1-3-28.

(b) The commissioner shall review a report filed under subsection (a) not later than September 1 of the year in which the report is filed. Upon completion of the review, the commissioner shall:

(1) issue a certification to the administrator:

(A) indicating that:

(i) the financial statement reflects a positive net worth; and

(ii) the administrator is currently licensed and in good standing; or

(B) noting deficiencies found in the report; or

(2) update an electronic data base that is maintained by the NAIC or by an affiliate or a subsidiary of the NAIC:

(A) indicating that the administrator is solvent and in compliance with this chapter; or

(B) noting deficiencies found in the report.

SECTION 17. IC 27-1-40 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]:

Chapter 40. Entry of Unauthorized Alien Companies

Sec. 1. As used in this chapter, "trusteed surplus" means the aggregate value of a United States branch's:

(1) surplus and reserve funds required under IC 27-1-6; and

(2) trust assets described in section 5 of this chapter;

plus investment income accrued on the items described in subdivisions (1) and (2) if the investment income is collected by the state for the trustees, less the aggregate net amount of all of the United States branch's reserves and other liabilities in the United States, as determined under section 6 of this chapter.

Sec. 2. As used in this chapter, "United States branch" means:

(1) an entity that is considered, for purposes of this chapter, to be a domestic company through which insurance business is transacted in the United States by an alien company; and

(2) the alien company's assets and liabilities that are attributable to the insurance business transacted in the United States.

Sec. 3. Indiana may serve as a state of entry to enable an alien company to transact insurance business in the United States through a United States branch if the United States branch:

(1) qualifies under IC 27 for a certificate of authority as if the United States branch were a domestic company organized under IC 27; and

(2) establishes a trust account that meets the following conditions:

(A) The trust account is established under a trust agreement approved by the commissioner with a United States bank.

(B) The amount in the trust account is at least equal to:

(i) the minimum capital and surplus requirements; or

(ii) the authorized control level risk based capital requirements;

whichever is greater, that apply to a domestic company that possesses a certificate of authority to transact the same kind of insurance business in Indiana as the United States branch will transact.

Sec. 4. (a) A trust account established under section 3(2) of this chapter must contain, at all times, an amount equal to the United States branch's reserves and other liabilities, plus the:

(1) minimum capital and surplus requirement; or

(2) authorized control level risk based capital requirement;

whichever is greater, that applies to a domestic company granted a certificate of authority under IC 27 to transact the same kind of insurance business as the United States branch transacts.

(b) One (1) or more trustees must be appointed to administer the trust.

(c) A trust agreement for a trust account established under section 3(2) of this chapter, and amendments to the trust

agreement:

(1) must be authenticated in a manner prescribed by the commissioner; and

(2) are effective only when approved by the commissioner after the commissioner finds all of the following:

(A) The trust agreement and amendments are sufficient in form and in conformity with law.

(B) All trustees appointed under subsection (b) are eligible to serve as trustees.

(C) The trust agreement is adequate to protect the interests of the beneficiaries of the trust.

(d) The commissioner may withdraw an approval granted under subsection (c)(2) if, after notice and hearing, the commissioner determines that one (1) or more of the conditions required under subsection (c)(2) for approval no longer exist.

(e) The commissioner may approve modifications of, or variations in, a trust agreement under subsection (c) if the modifications or variations are not prejudicial to the interests of Indiana residents, United States policyholders, and creditors of the United States branch.

(f) A trust agreement for a trust account established under section 3(2) of this chapter must contain provisions that:

(1) vest legal title to trust assets in the trustees and lawfully appointed successors of the trustees;

(2) require that all assets deposited in the trust account be continuously kept in the United States;

(3) provide for appointment of a new trustee in case of a vacancy, subject to the approval of the commissioner;

(4) require that the trustees continuously maintain a record sufficient to identify the assets of the trust account;

(5) require that the trust assets consist of:

(A) cash;

(B) investments of the same kind as the investments in which funds of a domestic company may be invested; and

(C) interest accrued on the cash and investments specified in clauses (A) and (B), if collectable by the trustees;

(6) establish that the trust:

(A) is for the exclusive benefit, security, and protection of:

(i) United States policyholders of the United States branch; and

(ii) United States creditors of the United States branch after all obligations to policyholders are paid; and

(B) shall be maintained as long as any liability of the United States branch arising out of the United States branch's insurance transactions in the United States is outstanding;

(7) establish that trust assets, other than income as specified in subsection (g), may not be withdrawn or permitted by the trustees to be withdrawn without the approval of the commissioner, except for any of the following purposes:

(A) To make deposits required by the law of any state for the security or benefit of all policyholders of the United States branch in the United States.

(B) To substitute other assets permitted by law and at least equal in value and quality to the assets withdrawn, upon the specific written direction of the United States manager of the United States branch when the United States manager is empowered and acting under general or specific written authority previously granted or delegated by the alien company's board of directors.

(C) To transfer the assets to an official liquidator or rehabilitator under a court order.

(g) A trust agreement for a trust account established under section 3(2) of this chapter may provide that income, earnings, dividends, or interest accumulations of the trust assets may be paid over to the United States manager of the United States branch upon request of the United States manager if the total amount of trust assets following the payment to the United States manager is not less than the amount required under subsection (a).

(h) A trust agreement for a trust account established under section 3(2) of this chapter may provide that written approval of the insurance supervising official of another state in which:

(1) trust assets are deposited; and

(2) the United States branch is authorized to transact insurance business;

is sufficient, and approval of the commissioner is not required, for

withdrawal of the trust assets in the other state if the amount of total trust assets after the withdrawal will not be less than the amount required under subsection (a). However, the United States branch shall provide written notice to the commissioner of the nature and extent of the withdrawal.

(i) The commissioner may at any time:

(1) make examinations of the trust assets of a United States branch that holds a certificate of authority under this chapter at the expense of the United States branch; and

(2) require the trustees to file a statement, on a form prescribed by the commissioner, certifying the assets of the trust account and the amounts of the assets.

(j) Refusal or neglect of a trustee to comply with this section is grounds for:

(1) the revocation of the United States branch's certificate of authority; or

(2) the liquidation of the United States branch.

Sec. 5. (a) The commissioner shall require a United States branch to do the following before granting the United States branch a certificate of authority to transact insurance business as described in section 3(1) of this chapter:

(1) Comply with this chapter and any other requirement of IC 27.

(2) Submit the following:

(A) A copy of the current charter and bylaws of the alien company that intends to transact business through the United States branch and any other documents determined by the commissioner to be necessary to provide evidence of the kinds of insurance business that the alien company is authorized to transact. Documents submitted under this clause must be attested to as accurate by the insurance supervisory official in the alien company's domiciliary jurisdiction.

(B) A full statement, subscribed and affirmed as true under penalty of perjury by two (2) officers or equivalent responsible representatives of the alien company in a manner prescribed by the commissioner, of the alien company's financial condition as of the close of the alien

company's latest fiscal year, showing the alien company's:

(i) assets;

(ii) liabilities;

(iii) income disbursements;

(iv) business transacted; and

(v) other facts required to be shown in the alien company's annual statement reported to the insurance supervisory official in the alien company's domiciliary jurisdiction.

(C) An English translation, if necessary, of any document submitted under this subdivision.

(3) Submit to an examination of the affairs of the alien company that intends to transact business through the United States branch at the alien company's principal office in the United States. However, the commissioner may accept a report of the insurance supervisory official in the alien company's domiciliary jurisdiction in lieu of the examination required under this subdivision.

(b) The commissioner may at any time hire, at a United States branch's expense, any independent experts that the commissioner considers necessary to implement this chapter with respect to the United States branch.

Sec. 6. (a) A United States branch shall file with the commissioner, not later than March 1, May 15, August 15, and November 15 of each year, all of the following:

(1) Statements of the insurance business transacted in the United States, the assets held by or for the United States branch in the United States for the protection of policyholders and creditors in the United States, and the liabilities incurred against the assets. All of the following apply to the statements filed under this subdivision:

(A) The statements must contain information concerning only the United States branch's assets and insurance business in the United States.

(B) The statements must be in the same form as statements required of a domestic company that possesses a certificate of authority to transact the same kinds of insurance business as the United States branch transacts.

(C) The statements must be filed as follows:

(i) Quarterly statements filed not later than May 15, August 15, and November 15 of each year for the first three (3) quarters of the calendar year.

(ii) An annual statement, filed not later than March 1 of each year.

(2) A trusteed surplus statement, in a form prescribed by the commissioner, at the end of the period covered by each statement described in subdivision (1)(C). In determining the net amount of the United States branch's liabilities in the United States to be reported in the statement of trusteed surplus, the United States branch shall make adjustments to total liabilities reported on the accompanying annual or quarterly statement as follows:

(A) Add back liabilities used to offset admitted assets reported in the accompanying quarterly or annual statement.

(B) Deduct:

(i) unearned premiums on insurance producer balances or uncollected premiums that are not more than ninety (90) days past due;

(ii) losses reinsured by reinsurers authorized to do business in Indiana, less unpaid reinsurance premiums to be paid to the authorized reinsurers;

(iii) reinsurance recoverables on paid losses from reinsurers not authorized to do business in Indiana that are included as an asset in the annual statement, but only to the extent that a liability for the unauthorized recoverables is included in the liabilities report in the trusteed surplus statement;

(iv) special state deposits held for the exclusive benefit of policyholders of a particular state that do not exceed net liabilities reports for the particular state;

(v) secured accrued retrospective premiums;

(vi) if the alien company transacting business through the United States branch is a life insurer, the amount of the alien company's policy loans to policyholders in the United States, not exceeding the amount of legal reserve

required on each policy, and the net amount of uncollected and deferred premiums; and

(vii) any other nontrust asset that the commissioner determines secures liabilities in a manner substantially similar to the manner in which liabilities are secured by the unearned premiums, losses reinsured, reinsurance recoverables, special state deposits, secured accrued retrospective premiums, and policy loans referred to in items (i) through (vi).

(3) Any additional information that relates to the business or assets of the alien company and is required by the commissioner.

(b) The annual statement and trusteed surplus statement described in subsection (a) must be signed and verified by the United States manager, the attorney in fact, or an empowered assistant United States manager, of the United States branch. Items of securities and other property held under a trust agreement must be certified in the trusteed surplus statement by the United States trustees.

(c) Each report concerning an examination of a United States branch conducted under section 4(i) of this chapter must include a trusteed surplus statement as of the date of examination and a general statement of the financial condition of the United States branch.

Sec. 7. (a) Before issuing a new or renewal certificate of authority to a United States branch, the commissioner may require satisfactory proof:

(1) in the charter of the alien company transacting business through the United States branch;

(2) by an agreement evidenced by a certified resolution of the alien company's board of directors; or

(3) otherwise as required by the commissioner;

that the United States branch will not engage in any insurance business not authorized by this chapter and by the alien company's charter.

(b) The commissioner shall issue a renewal certificate of authority to a United States branch if the commissioner is satisfied that the United States branch is not delinquent in any requirement

of this title and that the United States branch's continued insurance business in Indiana is not contrary to the best interest of the citizens of Indiana.

(c) A United States branch may not be:

(1) granted a certificate of authority to transact any kind of insurance business in Indiana that is not permitted to be transacted in Indiana by a domestic company granted a certificate of authority under IC 27; or

(2) authorized to transact an insurance business in Indiana if the United States branch transacts, anywhere in the United States, any kind of business other than an insurance business and business incidental to the kind of insurance business that the United States branch is authorized to transact in Indiana.

(d) A United States branch entering the United States through Indiana or another state may not be authorized to transact an insurance business in Indiana if the United States branch fails to substantially comply with any requirement of this title that:

(1) applies to a similar domestic company that is organized after July 1, 2007; and

(2) the commissioner determines is necessary to protect the interest of the policyholders.

(e) Unless the commissioner determines that the kind of insurance is not contrary to the best interest of the citizens of Indiana, a United States branch may not transact any kind of insurance business that is not permitted to be transacted in Indiana by a similar domestic company that is organized after July 1, 2007.

(f) A United States branch may not be authorized to transact an insurance business in Indiana unless the United States branch maintains correct and complete records of the United States branch's transactions that are:

(1) open to inspection by any person who has the right to inspect the records; and

(2) maintained at the United States branch's principal office in Indiana.

Sec. 8. If the commissioner determines from a quarterly or annual statement, trusteed surplus statement, or another report that a United States branch's trusteed surplus is less than:

(1) the minimum capital and surplus requirements; or

(2) the authorized control level risk based capital requirements;

whichever is greater, that apply to a domestic insurer granted a certificate of authority to transact the same kind of insurance business in Indiana, the commissioner may proceed under IC 27-9 against the United States branch as if the United States branch were an insurer in such condition that further transaction by the insurer of insurance business in United States would be hazardous to the insurer's policyholders, creditors, or residents of the United States.".

Page 7, line 34, delete "Armed Forces" and insert "**armed forces**".

Page 8, line 4, delete "Armed Forces" and insert "**armed forces**".

Page 8, after line 40, begin a new paragraph and insert:

"SECTION 22. IC 27-8-5-2.5, AS AMENDED BY P.L.127-2006, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.5. (a) As used in this section, the term "policy of accident and sickness insurance" does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy. ~~issued as an individual policy.~~

(5) A limited benefit health insurance policy. ~~issued as an individual policy.~~

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides ~~a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.~~ **indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:**

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) Worker's compensation or similar insurance.

(9) A student health ~~insurance policy.~~ **plan.**

(10) A supplemental plan that always pays in addition to other

coverage.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

(b) The benefits provided by:

(1) an individual policy of accident and sickness insurance; or

(2) a certificate of coverage that is issued under a nonemployer based association group policy of accident and sickness insurance to an individual who is a resident of Indiana;

may not be excluded, limited, or denied for more than twelve (12) months after the effective date of the coverage because of a preexisting condition of the individual.

(c) An individual policy of accident and sickness insurance or a certificate of coverage described in subsection (b) may not define a preexisting condition, a rider, or an endorsement more restrictively than as:

(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve (12) months immediately preceding the effective date of ~~enrollment in~~ the plan;

(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve (12) months immediately preceding the effective date of ~~enrollment in~~ the plan; or

(3) a pregnancy existing on the effective date of ~~enrollment in~~ the plan.

(d) An insurer shall reduce the period allowed for a preexisting condition exclusion described in subsection (b) by the amount of time the individual has continuously served under a preexisting condition clause for a policy of accident and sickness insurance issued under IC 27-8-15 if the individual applies for a policy under this chapter not more than thirty (30) days after coverage under a policy of accident and sickness insurance issued under IC 27-8-15 expires.

(e) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. Notwithstanding subsections (b) and (c), an individual policy of accident and sickness insurance may contain a

waiver of coverage for a specified condition and complications directly related to the specified condition if:

(1) the period for which the exemption would be in effect does not exceed two (2) years; and

(2) all of the following conditions are met:

(A) The insurer provides to the applicant before issuance of the policy a written notice explaining the waiver of coverage for the specified condition and complications directly related to the specified condition, including a specific description of each condition, complication, service, and treatment for which coverage is being waived.

(B) The:

(i) offer of coverage; and

(ii) policy;

include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition and specifying each related condition, complication, service, and treatment for which coverage is waived.

(C) The:

(i) offer of coverage; and

(ii) policy;

do not include more than two (2) waivers per individual.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) The insurer agrees to:

(i) review the underwriting basis for the waiver upon request one (1) time per year; and

(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(G) The waiver of coverage does not apply to coverage required under state law.

(H) An insurance benefit card issued by the insurer to the

applicant includes a telephone number for verification of coverage waived.

The insurer shall require an applicant to initial the written notice provided under subdivision (2)(A) and the waiver included in the offer of coverage and in the policy under subdivision (2)(B) to acknowledge acceptance of the waiver of coverage. An offer of coverage under a policy that includes a waiver under this subsection does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1. This subsection expires July 1, 2007.

(f) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. An insurer shall not, on the basis of a waiver contained in a policy as provided in subsection (e), deny coverage for any condition, complication, service, or treatment that is not specified as required in the:

(1) written notice under subsection (e)(2)(A); and

(2) offer of coverage and policy under subsection (e)(2)(B).

This subsection expires July 1, 2007.

(g) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. An individual who is covered under a policy that includes a waiver under subsection (e) may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28. This subsection expires July 1, 2007.

(h) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. Notwithstanding subsection (e), an individual policy of accident and sickness insurance may not contain a waiver of coverage for:

(1) a mental health condition; or

(2) a developmental disability.

This subsection expires July 1, 2007.

(i) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. A waiver under this section may be applied to a policy of accident and sickness insurance only at the time the policy is issued. This subsection expires July 1, 2007.

(j) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. An insurer or insurance producer shall not use this section to circumvent the guaranteed access and availability provisions of this chapter, IC 27-8-15, or the federal Health

Insurance Portability and Accountability Act of 1996 (P.L. 104-191). This subsection expires July 1, 2007.

(k) This subsection applies to a policy that is issued after June 30, 2003, and before July 1, 2005. A pattern or practice of violations of subsections (e) through (j) is an unfair method of competition or an unfair and deceptive act and practice in the business of insurance under IC 27-4-1-4. This subsection expires July 1, 2007.

SECTION 23. IC 27-8-5-15.6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 15.6. (a) As used in this section, "coverage of services for a mental illness" includes the services defined under the policy of accident and sickness insurance. However, the term does not include services for the treatment of substance abuse or chemical dependency.

(b) This section applies to a policy of accident and sickness insurance that:

(1) is issued on an individual basis or a group basis;

(2) is issued, entered into, or renewed after December 31, 1999; and

(3) is issued to an employer that employs more than fifty (50) full-time employees.

(c) This section does not apply to the following:

~~(1) An insurance policy listed under IC 27-8-15-9(b).~~

~~(2)~~ **(1)** A legal business entity that has obtained an exemption under section 15.7 of this chapter.

(2) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(3) Coverage issued as a supplement to liability insurance.

(4) Worker's compensation or similar insurance.

(5) Automobile medical payment insurance.

(6) A specified disease policy.

(7) A limited benefit health insurance policy.

(8) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(9) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care;

or

(B) gaps for deductibles or copayments.

(10) A supplemental plan that always pays in addition to other coverage.

(11) A student health plan.

(12) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

(d) A group or individual insurance policy or agreement may not permit treatment limitations or financial requirements on the coverage of services for a mental illness if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(e) An insurer that issues a policy of accident and sickness insurance that provides coverage of services for the treatment of substance abuse and chemical dependency when the services are required in the treatment of a mental illness shall offer to provide the coverage without treatment limitations or financial requirements if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(f) This section does not require a group or individual insurance policy or agreement to offer mental health benefits.

(g) The benefits delivered under this section may be delivered under a managed care system.

SECTION 24. IC 27-8-5-19, AS AMENDED BY P.L.127-2006, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 19. (a) As used in this chapter, "late enrollee" has the meaning set forth in 26 U.S.C. 9801(b)(3).

(b) A policy of group accident and sickness insurance may not be issued to a group that has a legal situs in Indiana unless it contains in substance:

(1) the provisions described in subsection (c); or

(2) provisions that, in the opinion of the commissioner, are:

(A) more favorable to the persons insured; or

(B) at least as favorable to the persons insured and more favorable to the policyholder;

than the provisions set forth in subsection (c).

(c) The provisions referred to in subsection (b)(1) are as follows:

(1) A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy will continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period. A provision under this subdivision may provide that the insurer is not obligated to pay claims incurred during the grace period until the premium due is received.

(2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless:

(A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or

(B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.

(3) A provision that a copy of the application, if there is one, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

(5) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy and that is not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice, diagnosis, care, or treatment was received by the person or recommended to the person during the six (6) months before the ~~enrollment~~ **effective** date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of:

(i) the end of a continuous period of twelve (12) months beginning on or after the ~~enrollment~~ **effective** date of the person's coverage; or

(ii) the end of a continuous period of eighteen (18) months beginning on the ~~enrollment~~ **effective** date of the person's coverage if the person is a late enrollee.

This subdivision applies only to group policies of accident and sickness insurance other than those described in section 2.5(a)(1) through 2.5(a)(8) and 2.5(b)(2) of this chapter.

(6) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice or treatment was received by the person during a period of three hundred sixty-five (365) days before the effective date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of the following:

(i) The end of a continuous period of three hundred sixty-five (365) days, beginning on or after the effective date of the person's coverage, during which the person did not receive medical advice or treatment in connection with the disease or physical condition.

(ii) The end of the two (2) year period beginning on the effective date of the person's coverage.

This subdivision applies only to group policies of accident and sickness insurance described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.

(7) If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

(A) premiums;

(B) benefits; or

(C) both premiums and benefits;

to be made if the age of a covered person has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be used.

(8) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate, in electronic or paper form, setting forth a statement that:

(A) explains the insurance protection to which the person insured is entitled;

(B) indicates to whom the insurance benefits are payable; and

(C) explains any family member's or dependent's coverage under the policy.

The provision must specify that the certificate will be provided in paper form upon the request of the insured.

(9) A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

(10) A provision stating that:

(A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim, forms usually furnished by the insurer for filing proof of loss; and

(B) if the forms are not furnished within fifteen (15) days after the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

(11) A provision stating that:

(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;

(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and

(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.

(12) A provision that:

(A) all benefits payable under the policy (other than benefits for loss of time) will be paid:

(i) immediately upon receipt of written proof of loss if the claim is filed by the policyholder; or

(ii) in accordance with IC 27-8-5.7 **if the claim is filed by the provider (as defined in IC 27-8-5.7-4;** and

(B) subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the

insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.

(13) A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of benefits for loss of life is subject to the provisions of the policy if no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount of five thousand dollars ($5,000), to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit.

(14) A provision that the insurer, **at the insurer's expense,** has the right and must be allowed the opportunity to:

(A) examine the person of the individual for whom a claim is made under the policy when and as often as the insurer reasonably requires during the pendency of the claim; and

(B) conduct an autopsy in case of death if it is not prohibited by law.

(15) A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of loss is filed in accordance with the requirements of the policy and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required by the policy.

(16) In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

(17) If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon the child's attainment of the limiting age for dependent children

set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child while the child is:

(A) incapable of self-sustaining employment because of mental retardation or mental or physical disability; and

(B) chiefly dependent upon the group member for support and maintenance.

A provision under this subdivision may require that proof of the child's incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120) days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the child's attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a mentally retarded or mentally or physically disabled child who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the child.

(18) A provision that complies with the group portability and guaranteed renewability provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191).

(d) Subsection (c)(5), (c)(8), and (c)(13) do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.

(e) If any policy provision required under subsection (c) is in whole or in part inapplicable to or inconsistent with the coverage provided by an insurer under a particular form of policy, the insurer, with the approval of the commissioner, shall delete the provision from the policy or modify the provision in such a manner as to make it consistent with the coverage provided by the policy.

(f) An insurer that issues a policy described in this section shall include in the insurer's enrollment materials information concerning the

manner in which an individual insured under the policy may:

(1) obtain a certificate described in subsection (c)(8); and

(2) request the certificate in paper form.

SECTION 25. IC 27-8-5-20 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 20. (a) All individual accident and health insurance policies, other than those issued pursuant to direct response solicitation, must have a notice prominently printed on the first page of the policy stating in substance that the policyholder has the right to return the policy:

(1) except as provided in subdivision (2), within ten (10) days of its delivery; **or**

(2) if the policy is a travel accident insurance policy, until the earlier of:

(A) thirty (30) days after the policy is delivered; or

(B) the date of departure;

and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason.

(b) All accident and health insurance policies issued pursuant to a direct response solicitation must have a notice prominently printed on the first page stating in substance that the policyholder has the right to return the policy:

(1) except as provided in subdivision (2), within thirty (30) days of its delivery; **or**

(2) if the policy is a travel accident insurance policy, until the earlier of:

(A) thirty (30) days after the policy is delivered; or

(B) the date of departure;

and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason.

(c) Notwithstanding subsection (b), a short term health insurance policy that is written for a period of less than sixty-one (61) days and issued pursuant to a direct response solicitation must have a notice prominently printed on the first page stating in substance that the policyholder has the right to return the policy within ten (10) days of the policy's delivery and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason.

SECTION 26. IC 27-8-5-27 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 27. (a) As used in this section, "accident and sickness insurance policy" means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis. The term does not include the following:

(1) Accident only, credit, dental, vision, ~~Medicare,~~ Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A limited benefit health insurance policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides ~~a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.~~ **indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:**

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) Worker's compensation or similar insurance.

(9) A student health ~~insurance policy.~~ **plan.**

(10) A supplemental plan that always pays in addition to other coverage.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

(b) As used in this section, "insured" means a child or an individual with a disability who is entitled to coverage under an accident and sickness insurance policy.

(c) As used in this section, "child" means an individual who is less than nineteen (19) years of age.

(d) As used in this section, "individual with a disability" means an individual:

(1) with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual; and

(2) who:

(A) has a record of; or

(B) is regarded as;

having an impairment described in subdivision (1).

(e) A policy of accident and sickness insurance must include coverage for anesthesia and hospital charges for dental care for an insured if the mental or physical condition of the insured requires dental treatment to be rendered in a hospital or an ambulatory outpatient surgical center. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the utilization standards for determining whether performing dental procedures necessary to treat the insured's condition under general anesthesia constitutes appropriate treatment.

(f) An insurer that issues a policy of accident and sickness insurance may:

(1) require prior authorization for hospitalization or treatment in an ambulatory outpatient surgical center for dental care procedures in the same manner that prior authorization is required for hospitalization or treatment of other covered medical conditions; and

(2) restrict coverage to include only procedures performed by a licensed dentist who has privileges at the hospital or ambulatory outpatient surgical center.

(g) This section does not apply to treatment rendered for temporal mandibular joint disorders (TMJ).

SECTION 27. IC 27-8-5.6-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. **(a)** As used in this chapter, the term "accident and sickness insurance" means any policy or contract covering one (1) or more of the kinds of insurance described in classes 1(b) or 2(a) of IC 1971, 27-1-5-1, as governed by IC 1971, 27-8-5.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A limited benefit health insurance policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 28. IC 27-8-12-18 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 18. ~~(a) As used in this section, "compensation" includes pecuniary and nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including, but not limited to, the following:~~

~~(1) Bonuses.~~

~~(2) Gifts.~~

~~(3) Prizes.~~

~~(4) Awards.~~

~~(5) Finders fees.~~

~~(b)~~ **(a)** An insurer or other entity that provides a commission ~~or other compensation~~ to an insurance producer or other representative for the sale of a long term care insurance policy may not violate the following conditions:

(1) The amount of the first year commission ~~or first year compensation~~ for selling or servicing the policy may not exceed two hundred percent (200%) of the amount of the commission ~~or other compensation~~ paid in the second year.

(2) The amount of commission ~~or other compensation~~ provided in years after the second year must be equal to the amount provided in the second year.

(3) A commission ~~or other compensation~~ must be provided each year for at least five (5) years after the first year.

~~(c)~~ **(b)** If an existing long term care policy or certificate is replaced, the insurer or other entity that issues the replacement policy may not provide, and its insurance producer may not accept, compensation in an amount greater than the renewal compensation payable by the replacing insurer on renewal policies, unless the benefits of the replacement policy or certificate are clearly and substantially greater than the benefits under the replaced policy or certificate.

~~(d)~~ **(c)** This section does not apply to the following:

(1) Life insurance policies and certificates.

(2) A policy or certificate that is sponsored by an employer for the benefit of:

(A) the employer's employees; or

(B) the employer's employees and their dependents.

SECTION 29. IC 27-8-14-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. **(a)** As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a); and

(2) is issued on a group basis.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A limited benefit health insurance policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides

coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 30. IC 27-8-14.1-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a); and

(2) is issued on a group basis.

(b) As used in this chapter, "accident and sickness insurance policy" does not include **the following:**

~~(1) accident only;~~

~~(2) credit;~~

~~(3) dental;~~

~~(4) vision;~~

~~(5) Medicare supplement;~~

~~(6) long term care; or~~

~~(7) disability income;~~

~~insurance.~~

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A limited benefit health insurance policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 31. IC 27-8-14.2-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a).

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy. ~~issued as an individual policy.~~

(6) A limited benefit health insurance policy. ~~issued as an individual policy.~~

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides ~~a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.~~ **indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:**

(A) hospital confinement, critical illness, or intensive care;

or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 32. IC 27-8-14.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. As used in this chapter, "health insurance plan" means any:

(1) hospital or medical expense incurred policy or certificate;

(2) hospital or medical service plan contract; or

(3) health maintenance organization subscriber contract;

provided to an insured.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy. ~~issued as an individual policy.~~

(6) A limited benefit health insurance policy. ~~issued as an individual policy.~~

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides ~~a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.~~ **indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:**

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other

coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 33. IC 27-8-14.7-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and

(2) is issued on a group basis.

(b) "Accident and sickness insurance policy" does not include ~~accident only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance.~~ **the following:**

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A limited benefit health insurance policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare;

and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 34. IC 27-8-14.8-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that:

(1) provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a); and

(2) is issued on a group basis.

(b) "Accident and sickness insurance policy" does not include ~~a policy providing accident only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance.~~ **the following:**

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A limited benefit health insurance policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 35. IC 27-8-16-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 5. (a) A claim review agent may not conduct medical claims review concerning health care services delivered to an enrollee in Indiana unless the claim review agent holds a certificate of registration issued by the department under this chapter.

(b) To obtain a certificate of registration under this chapter, a claim review agent must submit to the department an application containing the following:

(1) The name, address, telephone number, and normal business hours of the claim review agent.

(2) The name and telephone number of a person that the department may contact concerning the information in the application.

(3) Documentation necessary for the department to determine that the claim review agent is capable of satisfying the minimum requirements set forth in section 7 of this chapter.

(c) An application submitted under this section must be:

(1) signed and verified by the applicant; and

(2) accompanied by an application fee in the amount established under subsection (d).

The commissioner shall deposit an application fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(d) The department shall set the amount of the application fee required by subsection (c) and section 6(a) of this chapter in the rules adopted under section 14 of this chapter. The amount may not be more than is reasonably necessary to generate revenue sufficient to offset the costs incurred by the department in carrying out the department's responsibilities under this chapter.

(e) The department shall issue a certificate of registration to a claim review agent that satisfies the requirements of this section.

SECTION 36. IC 27-8-16-5.2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 5.2. (a) A person may not act as a claim review consultant concerning health care services delivered to an enrollee in Indiana unless the person holds a certificate of registration issued by the department under this chapter.

(b) To obtain a certificate of registration under this chapter, a person

must submit to the department an application containing the following:

(1) The name, address, telephone number, and normal business hours of the person.

(2) The name and telephone number of a person that the department may contact concerning the information in the application.

(3) Documentation necessary for the department to determine that the person is capable of satisfying the minimum requirements set forth in this chapter.

(c) An application submitted under this section must be:

(1) signed and verified by the applicant; and

(2) accompanied by an application fee in the amount established under subsection (d).

The commissioner shall deposit an application fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(d) The department shall set the amount of the application fee required by subsection (c) and section 6(a) of this chapter in the rules adopted under section 14 of this chapter. The amount may not be more than is reasonably necessary to generate revenue sufficient to offset the costs incurred by the department in carrying out the department's responsibilities under this chapter.

(e) The department shall issue a certificate of registration to a claim review consultant that satisfies the requirements of this section.

SECTION 37. IC 27-8-16-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 6. (a) To remain in effect, a certificate of registration issued under this chapter must be renewed on June 30 of each year. To obtain the renewal of a certificate of registration, a claim review agent or a claim review consultant must submit an application to the commissioner. The application must be accompanied by a registration fee in the amount set under section 5(d) of this chapter. **The commissioner shall deposit a registration fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.**

(b) A certificate of registration issued under this chapter may not be transferred unless the department determines that the person to which the certificate of registration is to be transferred has satisfied the requirements of this chapter.

(c) If there is a material change in any of the information set forth in an application submitted under this chapter, the claim review agent or claim review consultant that submitted the application shall notify the department of the change in writing not more than thirty (30) days after the change.

SECTION 38. IC 27-8-17-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9. (a) A utilization review agent may not conduct utilization review in Indiana unless the utilization review agent holds a certificate of registration issued by the department under this chapter.

(b) To obtain a certificate of registration under this chapter, a utilization review agent must submit to the department an application containing the following:

(1) The name, address, telephone number, and normal business hours of the utilization review agent.

(2) The name and telephone number of a person that the department may contact concerning the information in the application.

(3) Documentation necessary for the department to determine that the utilization review agent is capable of satisfying the minimum requirements set forth in section 11 of this chapter.

(c) An application submitted under this section must be:

(1) signed and verified by the applicant; and

(2) accompanied by an application fee in the amount established under subsection (d).

The commissioner shall deposit an application fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.

(d) The department shall set the amount of the application fee required by subsection (c) and section 10(a) of this chapter in the rules adopted under section 20 of this chapter. The amount may not be more than is reasonably necessary to generate revenue sufficient to offset the costs incurred by the department in carrying out its responsibilities under this chapter.

(e) The department shall issue a certificate of registration to a utilization review agent that satisfies the requirements of this section.

SECTION 39. IC 27-8-17-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. (a) To remain in

effect, a certificate of registration issued under this chapter must be renewed on June 30 of each year. To obtain the renewal of a certificate of registration, a utilization review agent must submit an application to the commissioner. The application must be accompanied by a registration fee in the amount set under section 9(d) of this chapter. **The commissioner shall deposit a registration fee collected under this subsection into the department of insurance fund established by IC 27-1-3-28.**

(b) A certificate of registration issued under this chapter may not be transferred unless the department determines that the entity to whom the certificate is to be transferred has satisfied the requirements of this chapter.

(c) If there is a material change in any of the information set forth in an application submitted under this chapter, the utilization review agent that submitted the application shall notify the department of the change in writing within thirty (30) days after the change.

SECTION 40. IC 27-8-24.1-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. As used in this chapter, "accident and sickness insurance policy" ~~has the meaning set forth in IC 27-8-5-27(a).~~ **means an insurance policy that provides at least one (1) of the types of insurance described in IC 27-1-5-1, Classes 1(b) and 2(a), and is issued on a group basis.**

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A limited benefit health insurance policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(9) A supplemental plan that always pays in addition to other coverage.

(10) A student health plan.

(11) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

SECTION 41. IC 27-8-29-15.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 15.5. Upon the request of a covered individual who is notified under section 15(d) of this chapter that the independent review organization has made a determination, the independent review organization shall provide to the covered individual all information reasonably necessary to enable the covered individual to understand the:**

(1) effect of the determination on the covered individual; and

(2) manner in which the insurer may be expected to respond to the determination.

SECTION 42. IC 27-13-10.1-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 4.5. Upon the request of an enrollee who is notified under section 4(c) of this chapter that the independent review organization has made a determination, the independent review organization shall provide to the enrollee all information reasonably necessary to enable the enrollee to understand the:**

(1) effect of the determination on the enrollee; and

(2) manner in which the health maintenance organization may be expected to respond to the determination.

SECTION 43. IC 27-13-27-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. Each health maintenance organization subject to this article shall pay to the commissioner **for deposit into the department of insurance fund established by IC 27-1-3-28** the following fees:

(1) Three hundred fifty dollars ($350) for filing:

(A) an application for a certificate of authority; or

(B) an application for an amendment to a certificate of authority.

(2) Fifty dollars ($50) for filing each annual report.

SECTION 44. IC 27-13-34-23 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 23. (a) A limited service health maintenance organization subject to this chapter shall pay to the commissioner **for deposit into the department of insurance fund established by IC 27-1-3-28** the following fees:

(1) For filing an application for a certificate of authority or an amendment to an application, three hundred fifty dollars ($350).

(2) For filing each annual report, fifty dollars ($50).

(b) In addition to the fees required by subsection (a), a limited service health maintenance organization subject to this chapter must pay the fees required by IC 27-1-3-15.

SECTION 45. IC 36-8-10-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 12. (a) The department and a trustee may establish and operate an actuarially sound pension trust as a retirement plan for the exclusive benefit of the employee beneficiaries. However, a department and a trustee may not establish or modify a retirement plan after June 30, 1989, without the approval of the county fiscal body which shall not reduce or diminish any benefits of the employee beneficiaries set forth in any retirement plan that was in effect on January 1, 1989.

(b) The normal retirement age may be earlier but not later than the age of seventy (70). However, the sheriff may retire an employee who is otherwise eligible for retirement if the board finds that the employee is not physically or mentally capable of performing the employee's duties.

(c) Joint contributions shall be made to the trust fund:

(1) either by:

(A) the department through a general appropriation provided to the department;

(B) a line item appropriation directly to the trust fund; or

(C) both; and

(2) by an employee beneficiary through authorized monthly deductions from the employee beneficiary's salary or wages. However, the employer may pay all or a part of the contribution for the employee beneficiary.

Contributions through an appropriation are not required for plans established or modifications adopted after June 30, 1989, unless the establishment or modification is approved by the county fiscal body.

(d) For a county not having a consolidated city, the monthly deductions from an employee beneficiary's wages for the trust fund may not exceed six percent (6%) of the employee beneficiary's average monthly wages. For a county having a consolidated city, the monthly deductions from an employee beneficiary's wages for the trust fund may not exceed seven percent (7%) of the employee beneficiary's average monthly wages.

(e) The minimum annual contribution by the department must be sufficient, as determined by the pension engineers, to prevent deterioration in the actuarial status of the trust fund during that year. If the department fails to make minimum contributions for three (3) successive years, the pension trust terminates and the trust fund shall be liquidated.

(f) If during liquidation all expenses of the pension trust are paid, adequate provision must be made for continuing pension payments to retired persons. Each employee beneficiary is entitled to receive the net amount paid into the trust fund from the employee beneficiary's wages, and any remaining sum shall be equitably divided among employee beneficiaries in proportion to the net amount paid from their wages into the trust fund.

(g) If a person ceases to be an employee beneficiary because of death, disability, unemployment, retirement, or other reason, the person, the person's beneficiary, or the person's estate is entitled to receive at least the net amount paid into the trust fund from the person's wages, either in a lump sum or monthly installments not less than the person's pension amount.

(h) If an employee beneficiary is retired for old age, the employee beneficiary is entitled to receive a monthly income in the proper amount of the employee beneficiary's pension during the employee beneficiary's lifetime.

(i) To be entitled to the full amount of the employee beneficiary's pension classification, an employee beneficiary must have contributed at least twenty (20) years of service to the department before retirement. Otherwise, the employee beneficiary is entitled to receive a pension proportional to the length of the employee beneficiary's

service.

(j) This subsection does not apply to a county that adopts an ordinance under section 12.1 of this chapter. For an employee beneficiary who retires before January 1, 1985, a monthly pension may not exceed by more than twenty dollars ($20) one-half (1/2) the amount of the average monthly wage received during the highest paid five (5) years before retirement. However, in counties where the fiscal body approves the increases, the maximum monthly pension for an employee beneficiary who retires after December 31, 1984, may be increased by no more or no less than two percent (2%) of that average monthly wage for each year of service over twenty (20) years to a maximum of seventy-four percent (74%) of that average monthly wage plus twenty dollars ($20). For the purposes of determining the amount of an increase in the maximum monthly pension approved by the fiscal body for an employee beneficiary who retires after December 31, 1984, the fiscal body may determine that the employee beneficiary's years of service include the years of service with the sheriff's department that occurred before the effective date of the pension trust. For an employee beneficiary who retires after June 30, 1996, the average monthly wage used to determine the employee beneficiary's pension benefits may not exceed the monthly minimum salary that a full-time prosecuting attorney was entitled to be paid by the state at the time the employee beneficiary retires.

(k) The trust fund may not be commingled with other funds, except as provided in this chapter, and may be invested only in accordance with statutes for investment of trust funds, including other investments that are specifically designated in the trust agreement.

(l) The trustee receives and holds as trustee all money paid to it as trustee by the department, the employee beneficiaries, or by other persons for the uses stated in the trust agreement.

(m) The trustee shall engage pension engineers to supervise and assist in the technical operation of the pension trust in order that there is no deterioration in the actuarial status of the plan.

(n) Within ninety (90) days after the close of each fiscal year, the trustee, with the aid of the pension engineers, shall prepare and file an annual report with the department. ~~and the state insurance department.~~ The report must include the following:

(1) Schedule 1. Receipts and disbursements.

(2) Schedule 2. Assets of the pension trust listing investments by book value and current market value as of the end of the fiscal year.

(3) Schedule 3. List of terminations, showing the cause and amount of refund.

(4) Schedule 4. The application of actuarially computed "reserve factors" to the payroll data properly classified for the purpose of computing the reserve liability of the trust fund as of the end of the fiscal year.

(5) Schedule 5. The application of actuarially computed "current liability factors" to the payroll data properly classified for the purpose of computing the liability of the trust fund as of the end of the fiscal year.

(o) No part of the corpus or income of the trust fund may be used or diverted to any purpose other than the exclusive benefit of the members and the beneficiaries of the members.

SECTION 46. IC 16-39-9-3 IS REPEALED [EFFECTIVE JULY 1, 2007].

SECTION 47. [EFFECTIVE JULY 1, 2007] **(a) As used in this SECTION, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.**

(b) As used in this SECTION, "committee" refers to the interim study committee to define "health insurance" established by subsection (c).

(c) There is established the interim study committee to define "health insurance". The committee shall only study and make recommendations to the general assembly concerning the manner in which accident and sickness insurance policies, self-insured plans, and health maintenance organization contracts that provide coverage for health care services are defined in the Indiana Code.

(d) The committee consists of the following members:

(1) Four (4) members of the house of representatives, to be appointed by the speaker of the house of representatives, not more than two (2) of whom may represent the same political party.

(2) Four (4) members of the senate, to be appointed by the president pro tempore of the senate, not more than two (2) of whom may represent the same political party.

(e) The committee shall operate under the policies governing study committees adopted by the legislative council.

(f) The affirmative votes of a majority of the members appointed to the committee are required for the committee to take action on any measure, including final reports.

(g) The committee shall submit a final report to the legislative council not later than October 31, 2007.

(h) This SECTION expires December 31, 2007.

SECTION 48. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "corporation" refers to the health and hospital corporation of Marion County.**

(b) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(c) As used in this SECTION, "program" refers to the health care management program established under subsection (d).

(d) Before June 1, 2008, the office shall establish a demonstration project for a health care management program to allow the office to do the following:

(1) Offer to Medicaid recipients who reside in Marion County the opportunity to receive Medicaid services provided solely by the corporation, including any clinic operated by the corporation. The offer must be extended to a number of Medicaid recipients that is sufficiently large to result in a percentage of recipients accepting the offer to provide meaningful data to guide the establishment and implementation of the program under subdivision (2).

(2) Require the corporation to establish and implement a program of health care management applying to all Medicaid recipients in Indiana and modeled on the United States Department of Veterans Affairs Quality Enhancement Research Initiative.

(3) Include in the program payment incentives for:

(A) health care providers; and

(B) administrators;

of the corporation to reward the achievement of objectives established for the program.

(e) The office and the corporation shall study the impact of implementing the program under subsection (d)(2), including the

impact the program has on the:

(1) quality; and

(2) cost;

of health care provided to Medicaid recipients in Indiana.

(f) The office shall consult with the Regenstrief Institute for Health Care in developing, implementing, and studying the program.

(g) The office shall apply to the United States Department of Health and Human Services for any amendment to the state Medicaid plan or demonstration waiver that is needed to implement this SECTION. The corporation shall assist the office in requesting the amendment or demonstration waiver and, if the amendment or waiver is approved, establishing and implementing the amendment or waiver.

(h) The office may not implement the amendment or waiver until the office files an affidavit with the governor attesting that the amendment or waiver applied for under this SECTION is in effect. The office shall file the affidavit under this subsection not more than five (5) days after the office is notified that the amendment or waiver is approved.

(i) If the office receives approval for the amendment or waiver under this SECTION from the United States Department of Health and Human Services and the governor receives the affidavit filed under subsection (h), the office shall implement the amendment or waiver not more than sixty (60) days after the governor receives the affidavit.

(j) The office may adopt rules under IC 4-22-2 to implement this SECTION.

(k) The office shall, before July 1 of each year, report to the legislative council in an electronic format under IC 5-14-6 concerning the demonstration project developed and implemented under this SECTION.

(l) This SECTION expires January 1, 2013.

SECTION 49. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "corporation" refers to the health and hospital corporation of Marion County.**

(b) As used in this SECTION, "insurer" includes the following:

(1) An insurer (as defined in IC 27-8-11-1).

(2) An administrator licensed under IC 27-1-25.

(3) A health maintenance organization (as defined in IC 27-13-1-19).

(4) A person that pays or administers claims on behalf of an insurer or a health maintenance organization.

(c) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(d) As used in this SECTION, "small employer" has the meaning set forth in IC 27-8-15-14.

(e) Before June 1, 2008, the office shall develop, with the corporation, a pilot project through which small employers that are unable to afford to offer health care coverage for employees of the small employers may obtain access to affordable health care coverage for the employees.

(f) The office may adopt rules under IC 4-22-2 to implement this SECTION.

(g) If the pilot project results in the availability of health care coverage to small employer groups through the pilot project at a premium rate that is at least twenty percent (20%) less than a comparable health benefit plan available to small employer groups in Indiana, an insurer may not enter into or enforce an agreement with the corporation that contains a provision that:

(1) prohibits, or grants the insurer an option to prohibit, the corporation from contracting with another insurer to accept lower payment for health care services than the payment specified in the agreement;

(2) requires, or grants the insurer an option to require, the corporation to accept a lower payment from the insurer if the corporation agrees with another insurer to accept lower payment for health care services;

(3) requires, or grants the insurer an option to require, termination or renegotiation of the agreement if the corporation agrees with another insurer to accept lower payment for health care services; or

(4) requires the corporation to disclose the corporation's reimbursement rates under contracts with other insurers.

(h) The office shall report to the legislative council in an electronic format under IC 5-14-6 concerning the development and

implementation of a pilot project under this SECTION before December 1, 2008.

(i) This SECTION expires December 31, 2013.

SECTION 50. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

(Reference is to SB 171 as reprinted February 14, 2007.)

and when so amended that said bill do pass.

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Representative Bardon